PEDIATRIC VISIT 6 to 11 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Child care:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

	CHOL	TB
(Circle)	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose/Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Tanner stage
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Choose foods from food guide pyramid ☐ Sociable at table ☐
Lowfat food choices, including milk ☐ Choose healthy foods at school ☐
5 fruits/vegetables daily ☐ No sweetened beverages ☐ 2hrs or less TV ☐

DEVELOPMENTAL SURVEILLANCE:

School: Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Responsibility for self ☐, for school ☐ Competitiveness ☐
Family vs. peer activities ☐ Caution with strangers/animals ☐
Teach address and phone number ☐

Parenting: Increased autonomy in decisions ☐ Communicate ☐
Praise and encourage ☐ Give allowance ☐
Assist in handling money ☐ Establish fair rules ☐

Play and communication: Organized sports ☐ Hobbies ☐
Monitor TV use ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐
Physical activity ☐ Smoking ☐ Second hand smoke ☐
Use sunscreen ☐ Tick prevention ☐

Sexuality: Prepare for physical changes ☐ Early sex education ☐
Masturbation ☐ Modesty ☐

Injury prevention: Seat belt ☐ Rear seat until age 12 years ☐
Riding toys in traffic environment ☐ Bicycle helmets ☐ Water safety ☐
Hot water 120° ☐ Fall prevention (playground) ☐ Matches ☐
Protective devices in sports ☐ Smoke detector/escape plan ☐
Poisoning (Plants, drugs, products) ☐ Poison control # ☐
Firearms (look alike toys; owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. Objective Hearing and Vision Tests (recommended)_____
3. PPD, if positive risk assessment ☐_____
4. Testing/counseling, if positive cholesterol risk assessment ☐_____
5. Dental visit advised ☐ or date of last visit_____
6. Next preventive appointment at _____
7. Referrals for identified problems: Yes / No *(specify)*_____

_____

_____

_____

Signatures:_____